

## **H.B. 5435, "An Act Concerning DNR Orders"**

Testimony for Public Hearing  
Public Health Committee  
March 16, 2012

Carin M. Van Gelder, MD FACEP FAAEM  
38 Jonathan Drive  
Storrs-Mansfield CT 06268  
*cell* 206.627.7414  
vangelder.ems@gmail.com

Madam Chair, and members of the committee:

My name is Carin Van Gelder. I live in Mansfield and I am providing testimony on HB 5435, An Act Concerning DNR Orders.

I am an Emergency Medicine physician and an EMS Medical Director, having completed my EMS fellowship at Yale University in 2004. I am currently the EMS Medical Director for Johnson Memorial Hospital in Stafford, and for Windham Community Memorial Hospital in Willimantic, and work in both Emergency Departments. I am the EMS Chair for the Connecticut College of Emergency Physicians (CCEP), serve on Connecticut's EMS Advisory Board, and participate in the Connecticut EMS Medical Advisory Committee (CEMSMAC).

I support a revised version of House Bill #5435. The purpose of revising this statute is to enable patients' demonstrated end-of-life wishes to be heard. EMS providers, which include first responders, EMTs, and paramedics, are only able to recognize DNR Orders in the format currently specified: orange DNR bracelets, or the official transfer forms as promulgated by DPH. These were specifically designed to "transfer" the order between health care institutions, in the late 1980s/early '90s. Today, EMS providers face many conflicts when they arrive at the scene of a dead or dying person. It's incredibly important to me, that these patients are heard, and also our EMS Providers.

Hospital staff also face the urgent need to determine an unstable patient's condition and wishes. However, by statute, physicians follow more specific advance directives, are supported by health

care representatives who must do as the patient would have wanted, and finally, have immunity from liability.

Making the decision to establish advance directives, and whether to wear a DNR bracelet in Connecticut, should mean that a patient has thought through what were to happen if their heart and/or breathing were to stop, and if they would want resuscitation (usually defibrillation and intubation). Many people are healthy and live at home, in assisted living, or at a nursing home, having determined advance directives and/or chosen DNR bracelets.

Better trained and better equipped EMS providers at ALL levels are performing resuscitations. These improvements, including provision of emotional support for family, are all based on better science, and are possible due to more involvement from physician medical oversight. This training also includes good information on outcomes; we know more about which patients have no chance of surviving certain mechanisms of injury.

Field personnel have embraced these advancements... because terminating or withholding resuscitation at the right time, is the right thing to do.

But per current regulations, field providers who are trained in assessment and treatment of critically ill and injured patients, cannot always do the right thing.

**\*\*They may not recognize clear DNR Orders that are not in the proper form (ie, out-of-state DNR Orders).**

**\*\*They MUST allow some "authorized representative" to revoke a DNR if they want (and this means pretty much anyone).**

**\*\*There is no immunity from liability.**

I'll illustrate the problem with this total absence of a true system for honoring end-of-life wishes, with this vignette:

An EMT radio'd me, for medical oversight (unusual but certainly encouraged), from a nursing home. "They're doing CPR on the dead guy; he's got a bracelet."

I asked for criteria determining he was dead. Answers were appropriate.

“Tell them to stop.”

“The nursing home won’t let them stop. They say he didn’t have THEIR DNR order filled out yet.”

“It’s against the law for them to refuse to recognize the orange bracelet. Stop resuscitation, and bring me the W-10 with his information.”

...

Later

“They want us to take the body.”

“No. They call the police and they have mechanisms for this. You should leave there.”

So we have many people living at home, who have made end-of-life decisions, but EMS is not allowed to recognize their decision. In my role as EMS Medical Director at the New Haven Sponsor Hospital Program, I listened to paramedics and EMTs become incredibly frustrated as they tried to "do the right thing". The potential patient volume was large; a population of >400,000, covered 284 sq miles. Cardiac arrest calls are about one a day. The crews to educate are many; My providers included almost 220 paramedics and about 600 EMTs, who were employed by 22 agencies in 12 towns.

In summary, Connecticut’s “DNR Orders”

- Aren’t what the patient would have wanted
- Demonstrate absence of a comprehensive system for honoring end-of-life wishes, regardless of patient’s location (in transit, home)
- Exemplify our fragmented health care system.

Revision of statute 19a-580d will enable regulations to

- Allow for reciprocity
- Allow for development of a program designed to improve communication of peoples’ wishes
- Remain consistent with statute specifying that a health care representative acting on behalf of the patient will do so, “based on what is known of [the patient’s] wishes.”

- Protect EMS personnel by adding immunity from liability – there is no other profession with more responsibility and less protection, in this state. Considering they are truly part of the few speaking up for these patients, I believe we can do better.

Thank you for the opportunity to speak. Please let me know if I can clarify anything.

